MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address Metroplex Diagnostics 200 Wynnewood Village Dallas, TX 75224	MDR Tracking No.: M4-04-3535-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 54 Texas Mutual Insurance Company	Date of Injury: Employer's Name: Seagull Installers, Inc. Insurance Carrier's No.: 99D0000344498

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
06/26/03	06/26/03	99242-25	90.00	0.00

PART III: REQUESTOR'S POSITION SUMMARY

The documentation enclosed supports the requirements of code 99242. Per TWCC guidelines, the office code has to have two key elements.

PART IV: RESPONDENT'S POSITION SUMMARY

The Commission has no jurisdiction to proceed with this medical dispute. The Provider did not submit the bill for reconsideration. Both Dr. Kogan and Dr. Souder initially submitted the charge for the same date of service and the level of service for the level of consultation was not documentation according to the MFG.

'JM – The Medical Fee Guideline States in the importance of proper coding "Accurate Coding of services rendered is essential for proper reimbursement", the services performed are not reimbursable as billed.'

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The EOB's received from both parties include evidence of reconsideration. However it's difficult to tell if Dr. Kogan's bill or Dr. Souder's bill was being reviewed in the reconsideration audit. Nonetheless, the Evaluation and Management Ground Rules (II. Concurrent Care) of the 1996 MFG do not allow reimbursement for duplicate services on the same date.

It is clear however, that the carrier did not reimburse either provider for this consultation. At the same time, the documentation requirements for this level of consultation require three key components. Regarding the consultation report in this dispute, while the history and examination notes are brief, they do not meet the requirements for the expanded problem focus history or examination to qualify for reimbursement under 99242.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

	Patti Lanfranco	June 28, 2005
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
P. O. Box 17787
Austin, Texas, 78744
or faxed to (512) 804-4011

A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____